Conference Name: **Cardiology procedure coding: Getting to the heart of therapeutic and diagnostic procedures**

Scheduled Conference Date: **Friday, October 7th 2005**

Scheduled Conference Time: **1:00 p.m.– 2:30 p.m. (Eastern), 12:00 p.m.– 1:30 p.m. (Central), 11:00 a.m.– 12:30 p.m. (Mountain), 10:00 a.m.–11:30 a.m (Pacific)**

Scheduled Conference Duration: **90 Minutes**

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Sincerely,

Frank Morello
Director of Multimedia
HCPro, Inc.
Cardiology procedure coding:  
Getting to the heart of therapeutic and diagnostic procedures

A 90-minute interactive audioconference

Friday, October 7, 2005

1:00 p.m.–2:30 p.m. (Eastern)  
12:00 p.m.–1:30 p.m. (Central)  
11:00 a.m.–12:30 p.m. (Mountain)  
10:00 a.m.–11:30 a.m. (Pacific)
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Web site: www.hcpro.com
Dear colleague,

Thank you for participating in our “Cardiology procedure coding: Getting to the heart of therapeutic and diagnostic procedures” audio-conference with Lolita M. Jones, RHIA, CCS. We are excited about the opportunity to interact with you directly and encourage you to take advantage of the opportunity to ask our experts your questions during the audio-conference. If you would like to submit a question before the audioconference, please send it to scoffey@hcpro.com and provide the program date in the subject line. We cannot guarantee your question will be answered during the program, but we will do our best to take a good cross-section of questions.

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Along with these audioconference materials, we have enclosed a fax evaluation. We value your opinion. After the audioconference, please take a minute to complete the evaluation to let us know what you think.

Thanks again for working with us.

Best regards,

Siva Coffey
Audioconference coordinator
Fax: 781/639-2982
E-mail: scoffey@hcpro.com
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Lolita M. Jones, RHIA, CCS

Lolita M. Jones, RHIA, CCS, is the principal of Lolita M. Jones Consulting Services and is the vice president of educational programs for Medical Marketing Resources, Inc. of Fort Washington, MD. She is the author of two editions of HCPro's The Modifier Clinic: A Guide to Hospital Outpatient Challenges and has authored a column on appropriate modifier use for the monthly newsletter Briefings on APCs for the last five years. She has over 15 years of experience in publishing, training, and auditing for the hospital outpatient and freestanding ambulatory surgery center (ASC) markets.
Exhibit A

Presentation by Lolita M. Jones, RHIA, CCS
Interventional Cardiology Coding
I. Overview

A. Interventional Cardiology - What is Expected?

Interventional cardiology procedures are nonsurgical procedures used to treat blocked coronary arteries and increase blood flow to the heart.

Interventional procedures are performed in the cardiac catheterization laboratory by a specialized cardiologist and a cardiovascular team of nurses and technicians.
After an interventional procedure, the coronary artery is opened, increasing blood flow to the heart.
Cardiology procedure coding: Getting to the heart of therapeutic and diagnostic procedures
Exhibit A

Cardiology procedure coding: Getting to the heart of therapeutic and diagnostic procedures
stent

stent stays in place after catheter is removed (mouse over image to see stent in place)
atherectomy

A cutter rotates to shave off fat in the window
rotoblation

Tip spins at high speed to grind plaque away
B. CPT 2006 Updates

At the time that this materials packet was prepared, the AMA had not yet released the 2006 updates to the *Physician's Current Procedural Terminology* (CPT) code book. Once this information is released, please do the following:

- **revise** all Interventional Cardiology Charge Tickets/Encounter Forms/Chargemasters if they contain CPT codes that have been changed in 2006 (or if new CPT codes need to be added)

- **revise** all Interventional Cardiology Charge Tickets/Encounter Forms/Chargemasters if they contain Healthcare Common Procedure Coding System (HCPCS) codes that have been changed in 2006 (or if new HCPCS codes need to be added)
  

- **educate** internal staff about the 2006 CPT codes that will impact the Interventional Cardiology coding and billing

- **review** your Medicare Carrier or Fiscal Intermediary (FI) local coverage determinations (LCDs) for new, revised or deleted policies based on the 2006 CPT code changes (go to:
  
II. Cardiac Catheterization

Cardiac catheterization is an invasive diagnostic medical procedure, which includes several components. The procedure begins when the physician introduces one or more catheters into peripheral arteries and/or veins. An example of a cardiac catheterization procedure log found following will help coders to better understand the sequence of events during catheterization.

The most common access point for cardiac catheterization is the femoral artery (used for left heart catheterization, aortography, coronary angiography, internal mammary artery injection, vein bypass graft injection and for other left heart procedures and coronary artery interventions). Right heart catheterization (as well as pulmonary arteriography) is most often accomplished by initial entry in the right femoral vein. Each catheter is then positioned in a branch vessel or a cardiac chamber. During the catheterization procedure, recordings are made of intracardiac and intravascular pressures; blood samples are obtained for measurement of oxygen saturation or blood gases and cardiac output measurements are made.

Angiography is frequently performed during a diagnostic catheterization, but the coding for angiography requires additional code selection. Angiography is the process of injecting a contrast medium (dye) into a blood vessel and imaging the vessel to determine the location and severity of obstructive lesions or other anatomic abnormalities. Repositioning of a catheter may be necessary during the procedure to perform injection of contrast for angiography. Injection of dye is usually done manually, but when angiography of a ventricular or atrial chamber is performed, a power injector may be used to deliver a sufficient amount of contrast in a short time to achieve an image of good resolution.

At the conclusion of the invasive procedure, the physician removes the catheters that were inserted and stops the bleeding from the catheterization site. Later, a final evaluation of hemodynamic and other data is completed and a report of the procedure is made.
A. CPT Coding Guidelines

Cardiac catheterization procedures are classified in the medicine section of CPT in the code range 93501–93572.

93501  Right heart catheterization
93503  Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes
93505  Endomyocardial biopsy
  Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous
93508  coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization
  Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery;
93510  percutaneous
  Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery;
93511  by cutdown
93514  Left heart catheterization by left ventricular puncture
93524  Combined transseptal and retrograde left heart catheterization
93526  Combined right heart catheterization and retrograde left heart catheterization
93527  (with or without retrograde left heart catheterization)
93528  Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart
catheterization)
93529  (with or without retrograde left heart catheterization)
93530  Right heart catheterization, for congenital cardiac anomalies
  Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac
anomalies
93531  Combined right heart catheterization and transseptal left heart catheterization through intact septum
93532  with or without retrograde left heart catheterization, for congenital cardiac anomalies
93533  Combined right heart catheterization and transseptal left heart catheterization through existing septal
opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies
93539  Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg,
  internal mammary), whether native or used for bypass
93540  Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous
  bypass grafts, one or more coronary arteries
93541  Injection procedure during cardiac catheterization; for pulmonary angiography
93542  Injection procedure during cardiac catheterization; for selective right ventricular or right atrial
  angiography
93543  Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography
93544  Injection procedure during cardiac catheterization; for aortography
93545  Injection procedure during cardiac catheterization; for selective coronary angiography (injection of
  radiopaque material may be by hand)
93555  Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization;
  ventricular and/or atrial angiography
93556  Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization;
  catheterization; with cardiac output measurement (separate procedure)
93557  Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous
  catheterization; with cardiac output measurement (separate procedure)
93561  Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement
  (coronary vessel or graft) during coronary angiography including pharmacologically induced stress;
93571  each additional vessel (List separately in addition to code for primary procedure)

Coding Tips:

- Carefully review medicine section codes 93501 to 93556 and their notes before selecting a code for cardiac catheterization.

- Cardiac catheterization procedure codes include
  - introduction, positioning and repositioning of catheter(s)
  - recording of intracardiac and intravascular pressure
  - obtaining blood samples for measurement of blood gases, dye dilution or other dilution curves
  - cardiac output measurements (dye dilution, Fick or other method, with or without rest and exercise, and/or other studies)
  - electrode catheter placement
  - final evaluation and report.

- CPT coding guidelines do not limit the number of catheter repositionings or pressure determinations included in the cardiac catheterization codes. For example, repositioning of the catheter and additional right heart pressure determinations made during the procedure are not separately reportable. (Source: February 2001 CPT Assistant newsletter, AMA).

- When oxygen saturation samples are obtained during the diagnostic cardiac catheterization procedure, only the appropriate cardiac catheterization codes should be reported. A separate code is not required to identify obtaining the blood samples used to determine oxygen saturation, as this is considered to be an inclusive component of the overall procedure. (Source: February 2001 CPT Assistant newsletter, AMA).

- CPT codes 93530–93533 (cardiac catheterization for congenital cardiac anomalies) are not limited to a specific age group. These codes were created for any age wherein a patient with a congenital anomaly has a cardiac catheterization performed.

- See codes 93501–93533 for the introduction of the cardiac catheter.

- See codes 93539–93545 for the angiography injection procedures performed in conjunction with cardiac catheterization. Codes 93539-93545 should only be reported once per cardiac catheterization (CPT 1998 Coding Symposium, November 13-14, 1997, Chicago, IL, AMA; November 2002 CPT Assistant newsletter, AMA.)
• See code 93555 and/or 93556 to report the technical details of angiography imaging supervision, interpretation and report. Codes 93555 and 93556 should be reported only once even though multiple angiographic procedures may have been performed (CPT 1998 Coding Symposium, November 13-14, 1997, Chicago, IL, AMA).

• When endomyocardial biopsy is performed in conjunction with a diagnostic cardiac catheterization, then code 93505 should be reported in addition to the component cardiac catheterization codes. However, if the physician performed the cardiac catheterization only as a means of obtaining the endomyocardial biopsy, and does not perform a separate diagnostic heart catheterization, then only the endomyocardial biopsy would be reported. (Source: CPT Assistant newsletter, April 2000, page 10).

• The term “conduits” as used in code 93539 – whether native or used for bypass – refers to arterial bypass vessels. (Source: October 2001 CPT Assistant newsletter, AMA).

• Transcatheter Therapy Infusion: Code 37202 was first intended and developed to describe prolonged infusions into peripheral arteries. Transcatheter infusion/injection of intracoronary drugs (eg, nitrates, calcium channel blockers) during cardiac catheterization procedures have become routine and are considered an integral part of both the diagnostic catheterization codes (93501 – 93556) and the coronary intervention codes (92980 – 92996), Cardiologists may, however, report code 37202 in unusual circumstances by appending the -59 modifier (distinct procedural service) and providing adequate documentation. (Source: CPT Assistant newsletter, January 1998, page 11.)
Cardiac Catheterization Critical Coding Questions

1. Does the patient have a congenital cardiac anomaly?
   a. Yes
   b. No

2. What side(s) of the heart was catheterized?
   a. left side
   b. right side
   c. right and left sides

3. If left heart catheterization, what method was used to access the left side of the heart?
   a. Percutaneous retrograde from the brachial artery, axillary artery, or femoral artery.
   b. Retrograde.
   c. Transseptal through intact septum.
   d. Left ventricular puncture (with or without retrograde left heart catheterization).

4. Was angiography performed? If yes, on which site(s)?
   a. Pulmonary.
   b. Right ventricular.
   c. Right atrial.
   d. Left ventricular.
   e. Left atrial.
   f. Selective coronary (injection of radiopaque material may be by hand).
   g. Aortic root.
   h. All sites listed above.

5. Was selective visualization/opacification of bypass graft(s) performed? If yes, on which site(s)?
   a. Arterial conduits (e.g., internal mammary)
   b. Aortocoronary venous bypass grafts

6. Which additional code(s) should be assigned to classify the imaging supervision, interpretation and report for the injection procedure(s) performed during the cardiac catheterization?
   a. 93555
   b. 93555 and 93556
Case Study: Left Heart Catheterization  
(93510, 93543, 93545, 93555, 93556)

Operative Report

Preoperative Diagnosis:

Postoperative Diagnosis:  
1. Two vessel Coronary artery disease involving the right coronary artery and left circumflex coronary artery.  
2. Moderate reduction in left ventricular systolic function.

Operation(s):  
Selective coronary angiography, retrograde left heart catheterization with left ventriculogram.

Description of Operation: After discussion of the procedure with the patient including the risks, complications, and benefits, and after informed consent was obtained, the patient was brought to the Cardiac Cath Lab.

The left groin was prepped and draped in the usual sterile manner, local anesthesia was obtained with 1% Lidocaine. Using Seldinger percutaneous technique, the left femoral artery was entered and a 6 French short introducer was placed in the left femoral artery. Selective coronary angiography was performed using 6 French Judkin’s left 4 and right 4 coronary catheters. All catheter exchanges were performed over a wire. A left ventriculogram was performed in the RAO projection with 40 cc of contrast at 12 cc per second.

At the completion of the procedure the diagnostic catheters were removed. The left groin introducer was removed and local hemostasis was obtained. The patient returned to his room in good condition. There were no complications.

Results:

Pressures: Left ventricle 174/16. Aorta 159/66, mean 100. On reviewing the pressure tracings from the LV to AO pullback, there was no significant systolic-gradient across the aortic valve.

Coronary angiography:

Left Coronary Artery: The left main coronary artery was essentially normal. The left anterior descending coronary artery had only minor plaque present in its mid-portion with no areas of focal or high grade obstruction seen. There was minimal plaquing of the diagonal coronary artery as well. The left circumflex coronary artery had sequential severe lesions of 90% and 80%. The left circumflex coronary artery then gave rise to a very large lateral branch which was essentially free of disease. A very small medial circumflex branch remained entirely within the AV groove.

Right coronary artery: The right coronary artery was totally obstructed at its origin. The posterior descending artery which arose from the right coronary artery could be seen filling retrogradely from the left coronary artery injection.

Left Ventriculogram: Left ventricular systolic function was moderately impaired. The inferobasal segment was akinetic. There was a mild hypokinesis involving the anterior wall.
Case Study: Right and Left Heart Catheterization
(93526, 93543, 93545, 93555, 93556)

Cardiac Catheterization Report

Preoperative Diagnosis: Recent chest pain plus positive thallium stress test

Postoperative Diagnosis: Hypertensive heart disease

Operation(s): Right and left heart catheterization and selective coronary angiography.

Description of operation: The patient was brought down to the cardiac catheterization laboratory on a stretcher. Her right groin was prepped and draped in the usual sterile fashion. After infiltrating the right groin with local anesthesia using Xylocaine, a 7–French hemaqit was inserted into the right femoral artery and an 8–French hemaqit was inserted into the right femoral vein. Following this, a Swan–Ganz catheter was advanced through the femoral venous hemaqit to the level of the right atrium, and pressures were recorded there. Pressures were also recorded in the right ventricle, pulmonary artery and pulmonary capillary wedge pressure position. Cardiac output was then obtained utilizing the thermodilution method. The Swan–Gant catheter was then pulled out of femoral venous sheath. Following that, a 7–French left coronary Judkin’s catheter was inserted over a guide wire to the level of the ascending aorta, and pressures were recorded there.

The left coronary ostium was then selectively cannulated, and multiple views of the left coronary artery were obtained in LAO and RAO position utilizing 5 to 10 cc of contrast material with each injection. The left coronary Judkin’s catheter was then exchanged over a guide wire with a 7–French right coronary Judkin’s catheter which was advanced, selectively cannulating the right coronary ostium. Two views of the right coronary artery were obtained in LAO and RAO position utilizing 5 to 10 cc of contrast material with each injection. The right coronary Judkin’s catheter was then exchanged over a guide wire with a 7–French pigtail catheter which was advanced to the level of the ascending aorta. It was then inserted into the left ventricular cavity.

After obtaining pressure recordings from the left ventricular cavity including left ventricular end-diastolic pressure, a left ventriculography was obtained in biplane mode utilizing 39 cc of contrast material. Post ventriculography pressures were then recorded, and the catheter was pulled back to the level of the ascending aorta. No gradient was noticed between the left ventricle and ascending aorta.

Final pressures were then recorded, and all catheters were removed. Hemostasis was achieved by applying manual pressure over the right groin. The patient then left the cardiac catheterization laboratory in stable condition.

Preliminary finding: Preliminary review of the video revealed the following:

1) Essentially normal coronary arteries

2) No significant left ventricular wall motion abnormality noted

3) Final details of angiographic findings as well as final conclusions will be reported separately.


III. Cardiovascular Ultrasound

Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report;

92978  initial vessel (List separately in addition to code for primary procedure)
Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report;

92979  each additional vessel (List separately in addition to code for primary procedure)

Coding Tips:

• Use 92979 in conjunction with 92978.

• Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement).
Case Study: Intravascular Ultrasound
(92978, 92979, 92979)

CARDIAC CATHETERIZATION REPORT EXCERPT

Because of the presence of heavy coronary calcification, it was elected to proceed with *intercoronary ultrasound examination of the LAD, circumflex and left main area*. This was performed expeditiously without difficulty.

**INTERCORONARY ULTRASOUND:**
The left main coronary artery measured 6.0 and did not contain any significant plaque. The left anterior descending reference vessel measured 3.0 to 3.9 from the distal to proximal portion. The proximal vessel contained significant luminal compromise with a diameter of 1.7 compromised by the presence of calcific eccentric plaque. The degree of cross-sectional narrowing was approximately 80%. The circumflex vessel measured 5 mm in its proximal portion and contained mild eccentric plaque. There were no significant obstructions.
IV. Percutaneous Transluminal Coronary Angioplasty (PTCA)

Angioplasty is a reparative procedure performed on a blood vessel. Used to open up arteries blocked by plaque, coronary angioplasty is frequently performed as a percutaneous transluminal coronary artery (PTCA) balloon dilatation. For balloon angioplasty to be effective, the tiny balloon must tear and crack the cholesterol and plaque deposits on the inner wall of the artery that block the supply of blood to the heart muscle. When this is accomplished, the blood vessel begins an effort to heal itself. Because the healing of the dilated, atherosclerotic artery is less than perfect, reocclusion of a balloon angioplasty site is relatively frequent.

A. CPT Coding Guidelines

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92973</td>
<td>Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92974</td>
<td>Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92978</td>
<td>Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92979</td>
<td>Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92980</td>
<td>Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92981</td>
<td>Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92982</td>
<td>Percutaneous transluminal coronary balloon angioplasty; single vessel (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92984</td>
<td>Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92995</td>
<td>Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92996</td>
<td>Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
Coding Tips:

- Code 92982 is assigned for single-vessel PTCA.
- Code 99284 is used for each additional vessel PTCA.
- Codes 92980, 92981 are used to report coronary artery stenting. Coronary angioplasty (92982, 92984) or atherectomy (92995, 92996), in the same artery, is considered part of the stenting procedure and is not reported separately. Codes 92973 (percutaneous transluminal coronary thrombectomy), 92974 (coronary brachytherapy) and 92978, 92979 (intravascular ultrasound) are add-on codes for reporting procedures performed in addition to coronary stenting, atherectomy, and angioplasty and are not included in the “therapeutic interventions” in 92980.

B. Medicare Modifier Guidelines

- Modifier -LC is used to describe a left circumflex coronary artery (for CPT codes 92980–92982, 92995, and 92996).
- Modifier -LD describes a left anterior descending coronary (for CPT codes 92980–92982, 92995, and 92996).
- Modifier -RC describes a right coronary artery (for CPT codes 92980, 92982, 92995, and 92996).
Case Study: PTCA (92982-RC, 93544, 93545, 93556)

CARDIAC CATHETERIZATION REPORT

PROCEDURES: Aortic root aortogram; coronary angioplasty

HISTORY: Patient is a 71-year-old man with hypertension and diabetes. He also has a history of chest pain and a prior history of coronary artery disease.

TECHNIQUE: A 6 Fr sheath was inserted into the right femoral artery utilizing the Seldinger technique. The aortic root was injected utilizing a 6 Fr 155 Pigtail catheter. Coronary angioplasty was performed, and the equipment utilized is described in the intervention summary section. 10,000 units of heparin were administered. Intracoronary nitroglycerin was given during this case. 170 cc of nonionic contrast were administered.

HEMODYNAMICS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Left Heart Pressures</th>
<th>Resting</th>
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<tbody>
<tr>
<td>Ao</td>
<td>Systolic  Diastolic  EDP  a  v  m</td>
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<tr>
<td>Ao</td>
<td>96</td>
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<td>Normal</td>
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<tr>
<td>Aortic Regurgitation</td>
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<tr>
<td>Comments</td>
<td>There were three aortic cusps. Unable to visualize a SVG to diagonal.</td>
<td></td>
</tr>
<tr>
<td>Coronary Angiography</td>
<td>Dominance: Right</td>
<td></td>
</tr>
<tr>
<td>Left Main</td>
<td>This vessel was not injected.</td>
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</tr>
<tr>
<td>Left Anterior Descending</td>
<td>This vessel was not injected.</td>
<td></td>
</tr>
<tr>
<td>Left Circumflex</td>
<td>This vessel was not injected.</td>
<td></td>
</tr>
<tr>
<td>Right Coronary Artery</td>
<td>This vessel was not injected. There was a 99% long segmental stenosis of the midsegment of the right posterior descending branch (RPDA) of the right coronary artery (RCA) at the anastomosis site of the bypass graft. The RPDA was small. Distal flow was decreased.</td>
<td></td>
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<tr>
<td>Indication for Intervention</td>
<td>Coronary intervention was indicated for treatment of a critical lesion in an asymptomatic patient status post a myocardial infarction.</td>
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<tr>
<td>Intervention Summary</td>
<td>Right Posterior Descending Branch of the RCA Mid 99%</td>
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</table>

Angioplasty was performed on the 99% stenosis in the midsegment of the RPDA at anastomosis site of bypass graft. According to the ACC/AHA classification system, this lesion was a type B2 lesion.

Angioplasty was accomplished through a 6 Fr RCB guide utilizing a Maverick® 15-mm balloon with a maximum size of 2.0 mm and a maximum inflation pressure of 10 atmospheres.

The final outcome was defined as successful. There was no residual stenosis following this intervention. Distal flow was normal.

The SVG to RPDA was engaged with RCB guide. It is widely patent. Unable to cross with luge or whisper wire. The Cross It® wire was then successfully advanced to the distal RPDA.

CONCLUSIONS

No evidence of aortic regurgitation   Successful angioplasty of the mid-RPDA lesion
V. Percutaneous Stent Placement

Intracoronary stenting, may be performed along with angioplasty. A stent is a small, wire mesh tube that can be inserted into a blood vessel to hold it open.

After the stent is inserted, it will become a permanent part of the artery wall, strengthening the wall while keeping the artery open for blood flow to the heart muscle. Some newer stents are coated with medication - they are called drug-eluting stents, and help in preventing restenosis or closure.

A. CPT Coding Guidelines

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<td>92980</td>
<td>Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel</td>
</tr>
<tr>
<td>92981</td>
<td>Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel</td>
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</tbody>
</table>

**Coding Tips:**

- The catheter introduction, positioning, and repositioning within the vessel is considered to be an inclusive component of a percutaneous intra-coronary stent placement procedure. Code 93508 (catheter placement) should not be reported in addition to 92980 (percutaneous stent placement). Code 92980 includes the introduction, positioning, and any repositioning of the catheter within the vessel. Any injection of dye and related imaging to determine the catheter/balloon/stent placement and post-procedural effectiveness are also included and should not be coded separately. (Source: *CPT Assistant* newsletter, August 2000, page 11).

- Codes 92980, 92981 are used to report coronary artery stenting. Coronary angioplasty (92982, 92984) or atherectomy (92995, 92996), in the same artery, is considered part of the stenting procedure and is not reported separately. Codes 92973 (percutaneous transluminal coronary thrombectomy), 92974 (coronary brachytherapy) and 92978, 92979 (intravascular ultrasound) are add-on codes for reporting procedures performed in addition to coronary stenting, atherectomy, and angioplasty and are not included in the “therapeutic interventions” in 92980.
B. Medicare Coding Guidelines – Drug Eluting Stents

TRANSCATHETER PLACEMENT OF A DRUG ELUTING INTRACORONARY STENT(S), PERCUTANEOUS, WITH OR WITHOUT OTHER THERAPEUTIC INTERVENTION, ANY METHOD, SINGLE VESSEL

G0290

TRANSCATHETER PLACEMENT OF A DRUG ELUTING INTRACORONARY STENT(S), PERCUTANEOUS, WITH OR WITHOUT OTHER THERAPEUTIC INTERVENTION, ANY METHOD, EACH ADDITIONAL VESSEL

G0291

Effective for services furnished on or after July 1, 2003:

In Transmittal A-03-051, CR 2771, CMS implemented payment under APC 0656, Transcatheter Placement of Drug-Eluting Coronary Stents, for two HCPCS codes that describe drug-eluting stents and their placement. CMS did not establish new HCPCS codes for the drug eluting coronary stents, however, they indicated that hospitals could include the charge for the drug-eluting stent in the charge for G0290 and G0291.

CMS also indicated that, alternatively, hospitals could bill separately for the stent using an appropriate Revenue Code, making certain that the charge for the G0290 and G0291 did not include the charge for the stent. Payment for placement of the stents, and the stents themselves, are made under APC 0656.

As of January 1, 2004, CMS reinstated C-codes for devices for cost reporting and cost tracking purposes. Therefore, hospitals have a third option to report charges for drug eluting stents. That is, hospitals may report HCPCS code C1874, “Stent, coated/covered, with delivery system” with an appropriate Revenue Code to report their charge for drug eluting coronary stents. When using HCPCS code C1874 to bill separately for drug eluting stents, hospitals should make certain that the charge for G0290 and G0291 for placement of the stents does not include the stent charge.
Case Study: Drug-Eluting Stent  
(G0290, C1874, 92982-LD, 93510, 93545, 93556)

Cardiac Catheterization Report

Preoperative Diagnosis:
Coronary artery disease.

Postoperative Diagnosis:
Coronary artery disease.

Procedure Performed:
Left heart catheterization with bilateral selective coronary arteriography and percutaneous transluminal coronary angioplasty of the left anterior descending coronary artery with intracoronary stent placement.

Indications:
Mr. J. is a 67 year old gentleman with a history of hypertension, hyperlipidemia, and type 2 diabetes. Recent cardiac evaluation for symptoms of presyncope included an exercise dual isotope myocardial perfusion study performed April 1, 2005, demonstrating a large region of exercise induced anteroapical ischemia. His previous cardiac history is negative for documented coronary artery disease or previous myocardial infarction. Cardiac catheterization is performed at present to evaluate the extent and severity of his underlying coronary artery disease and to determine optimal management.

Medications:

Description of Procedure:
Following premedication with Valium 10 mg p.o. and Benadryl 25 mg p.o., the patient was brought to the cardiac catheterization laboratory and prepped and draped in the usual sterile fashion. Under local anesthesia, the right femoral artery was entered via modified Seldinger technique and a 6 French right Judkins catheter was advanced through the proximal aorta and left ventricle where pressures were recorded. This catheter was employed to perform selective right coronary arteriography in a variety of axial and hemiaxial projections using small amounts of hand injected contrast. The right Judkins catheter was then exchanged for a 6 French 4 left Judkins catheter, which was employed to perform selective left coronary arteriography in a similar fashion. Following completion of diagnostic angiography, the decision was made to proceed with coronary intervention for the critical stenosis demonstrated in the proximal left anterior descending coronary artery.

The left Judkins catheter was exchanged for a 6 French JL-4 guiding catheter. Following the systemic administration of 5000 units of heparin intravenously, the guiding catheter was advanced to the proximal aorta and satisfactory engagement of the left main coronary artery established. A 3.0 x 20 mm Voyager balloon dilation catheter with a 0.014 inch BMW guide wire was advanced through the guiding catheter. The guide wire was cautiously advanced down the left anterior descending coronary through the site of subtotal occlusion in the proximal LAD. The tip of the wire was positioned far distally in the left anterior descending coronary. The balloon dilation catheter was advanced over the guide wire to the site of occlusion in the proximal LAD. Optimal position was confirmed with inlet pressure inflation. Two balloon dilatations were performed at that site to a maximum of 8 atmospheres for maximal duration 45 seconds. The Voyager balloon dilation catheter was then exchanged for a 3.5 x 20 mm Taxus Express II drug eluting stent. The Taxus stent was advanced over the guide wire to the site of stenosis in the proximal LAD. Optimal position was confirmed angiographically. The stent was deployed, with 9 atmosphere inflation of 45 seconds duration. A single post dilatation to 11 atmospheres for 30 seconds duration was performed. Final angiography demonstrated an excellent angiographic result.
C. Medicare Coding Guidelines – Device Coding

Effective for services provided on or after January 1, 2005, CMS requires hospitals to include device category codes on claims when such devices are used in conjunction with procedures billed and paid for under the Medicare hospital outpatient prospective payment system (OPPS). CMS’ goal is to improve the quality of the claims data in support of their transition to the use of all single claims to establish payment rates for those Ambulatory Payment Classification (APC) groups.

Specifically, if one “Allowed Device Code” is shown for one APC, that device would have to be billed on the claim for a service in that APC or the claim would be returned to the Hospital for correction. If more than one “Allowed Device Code” is shown for one APC, the provider would be required to bill one of the device codes shown on the same claim with the service in that APC for the claim to be accepted.

See the following URL for the October 1, 2005 MEDICARE Device Coding Edits:

http://www.cms.hhs.gov/providers/hopps/default.asp

An excerpt from the October 2005 edit appears below:
## Cardiology Procedure Coding: Getting to the Heart of Therapeutic and Diagnostic Procedures

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<th>APC</th>
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<th>Device A Description</th>
<th>Device B*</th>
<th>Device B Description</th>
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Cardiology procedure coding: Getting to the heart of therapeutic and diagnostic procedures
## Cardiology Procedure Coding: Getting to the Heart of Therapeutic and Diagnostic Procedures

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<td>C1733 Cath, EP, othr than cool-tip</td>
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<td>C2629 Intro/sheath, laser</td>
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<td>C2630 Cath, EP, cool-tip</td>
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<td>93651</td>
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<td></td>
<td>Ablate heart dysrhythm focus</td>
<td>0086</td>
<td>C1732 Cath, EP, diag/abl, 3D/vect</td>
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<td>93652</td>
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<td>C1894 Intro/sheath, non-laser</td>
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</table>
### Cardiology Procedure Coding: Getting to the Heart of Therapeutic and Diagnostic Procedures

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>SI</th>
<th>CI</th>
<th>Description</th>
<th>APC</th>
<th>Device A</th>
<th>Device A Description</th>
<th>Device B*</th>
<th>Device B Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93662</td>
<td>S</td>
<td></td>
<td>Intracardiac ECG (ice)</td>
<td>0670</td>
<td>C2629</td>
<td>Intro/sheath, laser</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0290</td>
<td>T</td>
<td></td>
<td>Drug-eluting stents, single</td>
<td>0656</td>
<td>C2630</td>
<td>Cath. EP, cool-tip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0291</td>
<td>T</td>
<td></td>
<td>Drug-eluting stents, each add</td>
<td>0656</td>
<td>C1874</td>
<td>Stent, coated/cov w/del sys</td>
<td>C1875</td>
<td>Stent, coated/cov w/o del sys</td>
</tr>
</tbody>
</table>

*Where a device code is shown under Device B, the edit requires one Device A code and one Device B code.*
RESOURCES – Medicare Memo
I. SUMMARY OF CHANGES: This transmittal issues a Recurring Update Notification that describes changes to the Hospital Outpatient Prospective Payment System (OPPS) to be implemented in the July 2004 update. The July 2004 Outpatient Code Editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) codes and ambulatory payment classification (APC) additions, changes, and other revisions identified in this notification. Unless otherwise noted, all changes addressed in this notification are effective for services furnished on or after July 1, 2004. OPPS additions, changes, and other revisions for drugs, biologicals and radiopharmaceuticals are addressed in CR 3322, which is being issued separately, and which includes changes in payment for certain drugs and biologicals that are mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
*IMPLEMENTATION DATE: July 6, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

<table>
<thead>
<tr>
<th>R/N/D</th>
<th>CHAPTER/SECTION/SUBSECTION/TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
III. FUNDING:
These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

<table>
<thead>
<tr>
<th>Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Requirements</td>
</tr>
<tr>
<td>Manual Instruction</td>
</tr>
<tr>
<td>Confidential Requirements</td>
</tr>
<tr>
<td>One-Time Notification</td>
</tr>
<tr>
<td>X Recurring Update Notification</td>
</tr>
</tbody>
</table>

*Medicare contractors only
Attachment – Recurring Update Notification

SUBJECT: July 2004 Update of the Hospital Outpatient Prospective Payment System (OPPS)

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification describes changes to the OPPS for the July 2004 update. The July 2004 Outpatient Code Editor (OCE) and OPPS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS) codes and ambulatory payment classification (APC) additions and changes, and other revisions, identified in this notification. Unless otherwise noted, all changes addressed in this notification are effective for services furnished on or after July 1, 2004. OPPS additions, changes, and other revisions for drugs, biologicals and radiopharmaceuticals are addressed in CR 3322, which is being issued separately.

B. Policy:

1. Service Added to New Technology APC

   The following service is assigned for payment in a new technology APC under the OPPS OCE, effective July 1, 2004.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Payment Rate</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9716*</td>
<td>07/01/04</td>
<td>S</td>
<td>1519</td>
<td>Radiofrequency Energy to Anal</td>
<td>Creation of Thermal Anal Lesions by Radiofrequency Energy</td>
<td>$1,750.00</td>
<td>$350.00</td>
</tr>
</tbody>
</table>

*This procedure is used for the treatment of fecal incontinence and involves the application of radiofrequency energy to the internal sphincter complex of the anus.

2. Drug-Eluting Stents

In the July 2003 Update of the Hospital Outpatient Prospective Payment System (OPPS), Transmittal A-03-051, Change Request 2771, issued June 13, 2003, we provided billing instructions for drug-eluting stents. The Food and Drug Administration (FDA) approved drug-eluting stents effective April 24, 2003. This notification provides updated billing instructions for the placement of drug-eluting stents, especially with the January 1, 2004 reinstitution of device C-codes.
for cost reporting purposes.

Effective for services furnished on or after July 1, 2003:

In Transmittal A-03-051, CR 2771, we implemented payment under APC 0656, Transcatheter Placement of Drug-Eluting Coronary Stents, for two HCPCS codes that describe drug-eluting stents and their placement. We did not establish new HCPCS codes for the drug eluting coronary stents, however, we indicated that hospitals could include the charge for the drug-eluting stent in the charge for G0290 and G0291. We also indicated that, alternatively, hospitals could bill separately for the stent using an appropriate Revenue Code, making certain that the charge for the G0290 and G0291 did not include the charge for the stent. Payment for placement of the stents, and the stents themselves, are made under APC 0656.

As of January 1, 2004, we reinstituted C-codes for devices for cost reporting and cost tracking purposes. Therefore, hospitals have a third option to report charges for drug eluting stents. That is, hospitals may report HCPCS code C1874, “Stent, coated/covered, with delivery system” with an appropriate Revenue Code to report their charge for drug eluting coronary stents. When using HCPCS code C1874 to bill separately for drug eluting stents, hospitals should make certain that the charge for G0290 and G0291 for placement of the stents does not include the stent charge.

3. Payment Change for CPT code 96567, “Photodynamic tx, skin”
Effective July 1, 2004, CPT code 96567, “Photodynamic tx, skin” is assigned to APC 1504.

4. Reporting Line Item Date of Service for Revenue Code without a HCPCS
In order to accurately determine hospital costs for purposes of updating payment rates for drugs and all other services paid under the hospital OPPS, and in order to package services appropriately, CMS relies on the service line date. Therefore, it is extremely important that the date and charge reported with a Revenue Code on a line without a HCPCS code represent a single date of service rather than a range of dates.
5. **Reminder Regarding Monthly Reporting of Repetitive Services**

Hospitals shall not bill the following Revenue Codes monthly, as these services are not repetitive Part B services:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Revenue Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>0250-0259</td>
</tr>
<tr>
<td>IV Therapy</td>
<td>0260-0269</td>
</tr>
<tr>
<td>Medical/Surgical Supplies</td>
<td>0270-0279</td>
</tr>
<tr>
<td>Medical/Surgical Supplies</td>
<td>0620-0624</td>
</tr>
<tr>
<td>Drugs Requiring Specific ID</td>
<td>0631-0637</td>
</tr>
</tbody>
</table>
Speaker resources

Lolita M. Jones, RHIA, CCS
Lolita M. Jones Consulting Services
1921 Taylor Avenue
Fort Washington, MD 20744
Phone: 301/292-8027
Fax: 301/292-8244
E-mail: LolitaMJ@aol.com

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• nursing
• pharmacy
• physician practice
• quality/patient safety
• safety

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CERTIFICATE OF ATTENDANCE

attended

“Cardiology procedure coding: Getting to the heart of therapeutic and diagnostic procedures”

a 90-minute audioconference

on

October 7, 2005

Suzanne Perney
HCPro, Inc., 2005
## Winter/Spring Education Program Schedule 2005

### January

**The Lodge at Rancho Mirage, Rancho Mirage, CA**

- **12th**
  - **VPMA/CMO Retreat:** Opportunities, constraints, and challenges of the VPMA/CMO role

- **13-14th**
  - **Medical Executive Committee Institute:** The essential training program for all medical staff leaders

### March

**Pointe Hilton Tapatío Cliffs Resort, Phoenix, AZ**

- **10-11th**
  - **Advanced Medical Staff Leadership Retreat:** Where today's leaders come to solve their toughest medical staff problems
  - **Credentialing and Privileging:** What physician leaders and credentialing professionals must know today!
  - **Effective JCAHO Survey Preparation for the Medical Staff**

### April

**Naples Beach Hotel and Golf Club, Naples, FL**

- **6th**
  - **The Problem Physician:** How to assess and manage impaired, unethical, dyscompetent and disruptive physicians

- **7-8th**
  - **Medical Staff Quality:** Practical strategies for effective peer review, physician performance feedback, and hospital performance improvement

### May

**The Westin on Michigan Avenue, Chicago, IL**

- **12-13th**
  - **Legal Challenges for Hospital and Medical Staff Leaders:** How to stay out of trouble, stay out of court, and improve physician relationships
  - **Medical Executive Committee Institute:** The essential training program for all medical staff leaders
  - **Physicians and Patient Safety:** Practical tools to help leaders change physician culture and behavior

- **13-14th**
  - **Surgical Team Summit:** Bringing together chiefs of surgery, chiefs of anesthesia, and surgical services leadership to tackle the toughest OR challenges

### June

**Mandalay Bay Resort & Casino, Las Vegas, NV**

- **2-3rd**
  - **The 8th Annual Credentialing Resource Center Symposium**
  - **A Practical Approach to JCAHO Survey Preparation**

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October

Hyatt Regency Embarcadero, San Francisco, CA

6-7th
Medical Executive Committee Institute: The essential training program for all medical staff leaders
Medical Staff Quality: Practical strategies for effective peer review, physician performance feedback, and hospital performance improvement

7-8th
Surgical Team Summit: Bringing together chiefs of surgery, chiefs of anesthesia, and surgical services leadership to tackle the toughest OR challenges

The Marriott Wardman, Washington, DC

19th
The Problem Physician

20-21st
Advanced Medical Staff Leadership Retreat: Where today’s leaders come to solve their toughest medical staff problems
Legal Challenges for Hospital and Medical Staff Leaders: How to stay out of trouble, stay out of court, and improve physician relationships

November

Loews Philadelphia Hotel, Philadelphia, PA

3-4th
A Practical Approach to JCAHO Survey Preparation
Credentialing and Privileging: What physician leaders and credentialing professionals must know today!
Physicians and Patient Safety: Practical tools to help leaders change physician culture and behavior

The Ritz-Carlton Palm Beach, Palm Beach, FL

16th
VPMA/CMO Retreat

17-18th
Effective JCAHO Survey Preparation for the Medical Staff
Medical Executive Committee Institute: The essential training program for all medical staff leaders

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